

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



August 18, 1982

ALL-COUNTY INFORMATION NOTICE I-110-82

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: MEDICAL REPORT (CA 61, FORMERLY CA 341)

REFERENCE:

Attached is a copy of the revised Medical Report. The form is used to assess an AFDC applicant's physical, not mental, incapacity.

Substantial revisions have been made with extensive involvement by the County Forms Advisory Committee. They include:

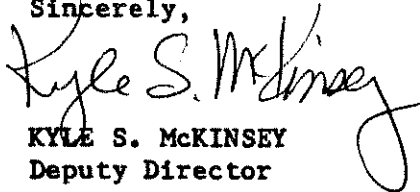
- Elimination of the green cover sheet. Instructions to the physician are now on the top of the form.
- Addition of a release of information section. A separate release form will no longer have to be sent to the physician.
- Addition of eligibility worker and district identification to help counties return the completed form to the proper person. Space for the case name and number has been added to assist in locating the case.
- Providing for the physician's address to be placed for use in a standard #10 window envelope.
- Other minor revisions which make the form easier for the eligibility worker and physician to complete.

Counties should continue to use their supply of CA 341 forms. The revised CA 61 form is now being printed and will be available from the DSS warehouse as soon as the warehouse supply of CA 341 forms has been depleted.

Suggestions for future revisions may be addressed to the AFDC Forms Coordinator, AFDC Program Systems Bureau, Mail Station 16-31, 744 P Street, Sacramento, CA 95814.

If you have any questions regarding the CA 61, you may contact your AFDC Program Management Consultant at (916) 445-4458.

Sincerely,

A handwritten signature in black ink, appearing to read "Kyle S. McKinsey". The signature is written in a cursive style with a large, looping "K" and "M".

KYLE S. MCKINSEY
Deputy Director

Attachment

cc: CWDA

Distribution:

White: County
Goldenrod: Physician

Medical Report
Aid to Families With Dependent Children
(AFDC)

DISTRICT UNIT	ELIGIBILITY WORKER	DATE
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Instructions to Physician: *The AFDC applicant named below claims to be physically incapacitated. This report should provide the welfare department with an assessment of any medically verifiable physical condition(s) which would make the applicant unable to provide normal care for the child(ren), or prevent the applicant from accepting and/or keeping employment.*

Applicant and County: Please Complete This Section

I, _____ hereby authorize _____
NAME OF APPLICANT NAME OF PHYSICIAN HOSPITAL
to release medical information requested by this form to the county welfare department. I also authorize the county welfare department to release the same information to the Department of Rehabilitation.

(Applicant's Signature) _____ (Date) _____

CASE NAME	PATIENT'S LAST NAME	FIRST	MIDDLE
CASE NUMBER	AGES OF CHILDREN IN HOME		

Physician or Authorized Staff Member: Please Complete This Section

1. Medical Problem:
a. Diagnosis and Prognosis _____

- b. Probable Duration of Incapacity: ☐ Permanent, ☐ Temporary _____, _____, ☐ Uncertain at this time
FROM TO
(Please explain if you believe that further laboratory work or a more complete examination will be necessary before anyone can arrive at a judgment of the degree and permanence of the disability.)

- c. Date of Last Exam: _____ Date of Next Appointment: _____

2. Functional Limitations: (Explain below all child care or employment limitations checked. Read across.)

Caused by: ☐ Pain ☐ Weakness ☐ Structural limitations ☐ Dyspnea ☐ Other (Specify below)
Patient is: ☐ Bedfast ☐ Chairbound ☐ Housebound ☐ Totally disabled (Explain below)
Patient can perform: ☐ Full-time hard labor ☐ Part-time hard labor ☐ No hard labor ☐ Limited full-time work ☐ Limited part-time work ☐ No work

In your opinion, could this person provide normal care for the child(ren)? ☐ Yes ☐ No

Comments and Limitations: _____

SIGNATURE AND TITLE OF PERSON COMPLETING FORM	TELEPHONE NUMBER	DATE
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• Physician's Address

• County Stamp